INSIGHT

JANUARY 2026 | ISSUE 8

5 ESSEX
CHAMBERS

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ISSUE 08 | JANUARY 2026

Welcome from the Editors

Alison Hewitt and Mark Thomas

We are delighted to welcome you to this New Year edition of Insight, 5 Essex Chambers' periodic review of matters of interest to those concerned with Inquests and Public Inquiries.

This edition includes some "Letters Home from Inquiry-land". There are an ever-increasing number of public inquiries touching on many aspects of public life; indeed, members of chambers have played key roles in many of them. We are struck by how they differ in their length, approach, and impact, some fading from the media gaze quite quickly. We have gathered some reflections from a few of our members of chambers working in Inquiry-land.

We start with **Bilal Rawat KC's** insights on the challenges he faced as leading counsel to the Commission of Inquiry investigating corruption amongst public officials in the British Virgin Islands. **Jonathan Landau** considers the flexible nature of a non-statutory inquiry. **Jonathan Dixey** updates us on the progress of the profoundly sad Southport Inquiry. **Claire Palmer** addresses the slow pace of the Undercover Policing Inquiry and, finally, **Jennifer Wright** reflects on the conclusion of the Brook House Inquiry and the challenges of implementing its recommendations.

Also of interest to those concerned with the world of inquiries will be the article from **John Goss** and **Paige Jones**, arising from the Independent Inquiry Relating to Afghanistan (IIA), in which they tell us whether an inquiry is or is not a "court or tribunal" and - just as importantly – why it matters!

For those of you more focused on inquests, fear not. We have a series of articles considering various procedural pauses to the inquest process. **Alex Ustych** writes about the antiquated regime which governs the High Court's power to quash the outcome of a coronial investigation and order a new inquest. **Bobby Talalay** considers the implications of a Coroner's Court becoming functus and **Mark Thomas** reflects on the dilemma of resuming an inquest following a homicide trial. Finally, **Alison Hewitt** provides an update on the regular stream of reviews by the High Court of Article 2, this time through the prism of three police related deaths.

Look out too for the Note from your Editors at the end of this issue in which we write about the recent Police Accountability Rapid Review and its potential impact on the Unlawful Killing conclusion.

We hope this edition of Insight will be of use and of interest and we wish all our readers well for the year ahead.

Inquiry-land 1: Wish you were here? A traveller's tale from the Commission of Inquiry in the British Virgin Islands

Bilal Rawat KC recounts his sojourn in the Caribbean

> *The internet speaks of* 'powdery white beaches' and 'sapphire-toned waters', and a 'verdant paradise'

The British Virgin Islands (BVI) are an archipelago of tropical islands in the Caribbean. The average daily temperature is 24°c in summer but a mere 21°c in winter. The internet speaks of '*powdery white beaches'* and *'sapphire-toned waters'*, and a '*verdant paradise*'. None of this, of course, came to mind when, three lockdowns into the COVID-19 pandemic, I was approached to act as counsel to a Commission of Inquiry (COI) investigating political corruption in the BVI to be led by The Rt. Hon. Sir Gary Hickinbottom, a senior member of the Court of Appeal. What I knew then of the BVI was that they had suffered terribly when hit by hurricanes Irma and Maria in 2017, were often criticised for their approach to financial transparency, and that one island was owned by Sir Richard Branson.

> *prompted by concerns over the mismanagement of public funds, political interference in the awarding of government contracts, intimidation of public officers, and the encroachment of organised crime (just two months before, cocaine with a street value of $250M had been found at a police officer's home)*

A British Overseas Territory, the BVI's constitution provides for a legislature comprising the Governor, exercising executive authority on behalf of the King, and an elected House of Assembly. The ruling administration in the latter forms a cabinet led by a Premier. It has responsibility for areas such as education, finance, welfare, and public works, while the Governor chairs cabinet and retains responsibility for national security, the courts, and the civil service. On 19 January 2021, Gus Jaspert, the then Governor, announced the COI. His decision was prompted by concerns over the mismanagement of public funds, political interference in the awarding of government contracts, intimidation of public officers, and the encroachment of organised crime (just two months before, cocaine with a street value of $250M had been found at a police officer's home).

The COI's terms of reference were broad: to establish whether there was information that corruption, abuse of office or other serious dishonesty in relation to public officials, elected or not, may have taken place in recent years and to make recommendations to improve the standard of governance and of the law enforcement and justice system. As with any inquiry, the COI could not determine matters of civil or criminal liability. It was fortunate that the secretary to the COI was a highly experienced diplomat seconded from the Foreign Office who moved quickly to set up the processes expected of a UK inquiry but new for the Eastern Caribbean.

So it was that, having left a near-empty Gatwick at the end of April 2021, I found myself beginning our first hearings remotely from quarantine. Key parties involved included the BVI's Attorney General, the Premier, the BVI Government, all represented by a team led by Sir Geoffrey Cox KC, MP.

From the beginning there were challenges. Potential witnesses repeatedly expressed fears that, if discovered to have been in contact with the inquiry, they would be targeted and victimised. Some just would not come forward. Others would do so only on condition of complete anonymity, a difficult guarantee in a small community. Despite early requests for disclosure, the slow pace at which it was provided by the BVI government and its incomplete nature, was a persistent issue.

At first, the BVI public was deeply divided over the COI. The territory has an active online press with widespread use of social media. Sections of the press and some commentators pointed to an earlier inquiry in the Turks and Caicos Islands which had led to the suspension of that territory's constitution and, in effect, the imposition of direct rule from London. They painted the COI as a British imposed process with a pre-determined outcome. Allegations of a political agenda and cultural insensitivity circulated alongside personal, and sometimes peculiar, criticisms of the Commissioner and his team. That team was a small one with just six of us in the BVI including the Commissioner. In a small jurisdiction, we became well-known and so were more

Inquiry-land 1: Wish you were here?
A traveller's tale from the Commission of Inquiry in the British Virgin Island

Bilal Rawat KC

directly exposed to criticisms than might have been the case in the UK.

> *"… $1M spent on a never-finished school wall; $7M committed to a national airline whose planes never flew; the allocation of Covid grants contrary to policy; overt political interference in supposedly independent statutory bodies; the sale of Crown Land valued at $600K for $1"*

Public debate over an inquiry which could have profound constitutional implications is important. The COI's commitment to transparency was key to changing public opinion. While there was no local precedent for rules or protocols of the sort seen in UK inquiries, the COI published rules and protocols to show how it would operate. Ensuring procedural fairness was fundamental. Witnesses were notified of potential criticisms in advance and were able to respond in writing and at an oral hearing. The decision to deal with potential criticisms during the evidence gathering, rather than report writing stage, was not subject to challenge and reduced delay.

Livestreaming the public hearings proved effective in engaging with the BVI public. They generated considerable interest with average views of over 7,000 per day. Some of this was no doubt down to the novelty of seeing senior political figures and public officers questioned. It meant, however, that those most affected by the inquiry could judge the thoroughness with which issues were investigated. That the public could see that all witnesses were treated with courtesy, had legal representation if necessary, and that the COI was prepared to ask difficult questions of, for example, Mr Jaspert and his successor, contributed significantly to changing attitudes as to the independence of the inquiry.

> *"… a thorough and timely inquiry can be delivered, however difficult the circumstances"*

The COI adopted a topic-based approach. There followed many hours and days of consuming and painstaking work. The topic-based approach meant witnesses were called more than once, including the Premier, Andrew Fahie, a flamboyant character who insisted on beginning his evidence sessions with a prayer. Matters brought to public attention included the inability to hold elected representatives accountable for their persistent failure to declare financial interests; their near unfettered discretion to distribute financial grants to constituents; large contracts being awarded without cabinet approval and with little regard to procurement requirements; the $1M spent on a never-finished school wall; $7M committed to a national airline whose planes never flew; the allocation of Covid grants contrary to policy; overt political interference in supposedly independent statutory bodies; the sale of Crown Land valued at $600K for $1; the obstruction of government auditors; and the attempt in cabinet to grant BVI citizenship to a convicted rapist serving his sentence overseas despite a residency requirement.

> *"… the COI proved to be a rare example of an inquiry whose recommendations were accepted in full"*

The COI report was submitted to the Governor on 4 April 2022. It runs to 946 pages. To produce a report, which had to address a wide range of matters to have credibility, within 15 months showed that a thorough and timely inquiry can be delivered, however difficult the circumstances. For me, that was a tribute to the commitment of the colleagues with whom I worked in the BVI. The twist in the tale was the arrest of Andrew Fahie on drug trafficking charges in Miami[1]. That briefly drew attention away from the COI's recommendations. That it recommended suspending the constitution generated headlines, but there were another 48 recommendations intended to improve systems of governance, law enforcement, and justice. Ultimately, the COI proved to be a rare example of an inquiry whose recommendations were accepted in full. The UK Government agreed not to enforce the Order in Council which would suspend the BVI's constitution if the BVI government satisfactorily implemented all other recommendations. The Order is due to be revoked in March 2026.

Looking back, the COI was not just an interesting case in what is indeed a verdant paradise; it was also an opportunity to contribute to the prevention of systemic abuses which could, if not addressed, jeopardise the BVI's progress towards self-determination.

[1]He is now serving 11 years in a US Federal prison.

Inquiry-land 2: A Fuller Inquiry?

Jonathan Landau reflects on whether the flexible nature of the non-statutory Fuller Inquiry led to a more comprehensive outcome

David Fuller sexually abused the bodies of 101 deceased women and girls in the mortuaries of two Kent hospitals on 140 occasions between 2005 and 2020.

The purpose of the Fuller Inquiry was to establish how he was able to commit those horrific crimes, apparently unnoticed, and to make recommendations with the aim of preventing anything similar happening again.

> *"The Independent Inquiry was non-statutory and so had a great deal of flexibility as to procedure"*

Phase 1 of the Inquiry concerned matters relating to the Trust in question, whilst Phase 2 considered the broader national picture and wider lessons for the NHS and other settings.

The Independent Inquiry was non-statutory and so had a great deal of flexibility as to procedure. In Phase 2, for example, the Inquiry's work included consideration of the role of Designated Individuals under the Human Tissue Act, and the regulation of settings where deceased people are kept. Seminars were held regarding both. In respect of the regulation seminar, a wide range of leaders attended including from the NHS, the Royal College of Pathologists, representative bodies, and professional and provider regulators. The output from those seminars features extensively in the Phase 2 report. Seminars are not unique to non-statutory Inquiries. However, the procedural flexibility of non-statutory Inquiries, including the Chair's discretion as to whether or not to take evidence by way of public hearings with conventional questioning of witnesses, can arguably lead to participants being less defensive and more amenable to openly contributing to an Inquiry's work.

At a time when questions are being raised about the duration of Public Inquiries, as well as their effectiveness and their cost, there may be scope for considering how injecting greater flexibility to statutory inquiries may add value without detracting from their ability to meet their terms of reference.

Jonathan Landau was Counsel to the Inquiry and facilitated the seminar on regulation.

Inquiry-land 3: The Southport Inquiry

Jonathan Dixey

On 29 July 2024 a brutal knife attack was carried out at a children's dance club in Southport. The perpetrator murdered three young girls, Elsie Dot Stancombe, Alice da Silva Aguiar and Bebe King, and injured ten other people.

Sixteen others survived the attack but live with the emotional scars. The Home Secretary established the Southport Inquiry, issuing its Terms of Reference in April 2025. Hearings commenced in July 2025 with evidence about the impact of the attack on the families of the bereaved and on the other victims.

Inquiry-land 3: The Southport Inquiry

Jonathan Dixey

> *“Whilst the scope of the Southport Inquiry is considerably more focused than many other inquiries”*

In September, October and November 2025 the Inquiry called evidence from a variety of individuals and organisations. Those included the suppliers of knives and other items which could be used as weapons, delivery companies along with the internet shopping behemoth Amazon, social media companies, the police, central and local Government, and mental health clinicians. The Inquiry also heard evidence from the parents and brother of the perpetrator. This evidence is focused on ‘Phase 1’ of the Inquiry’s work: to establish a definitive account of the events leading up to the Southport attack and the attack itself, as well as reviewing the decision-making and information-sharing by local services and agencies which interacted with the perpetrator. In 2026, the Inquiry is expected to commence the second phase of its work, in which it will consider the adequacy of multi-agency systems to address the risk posed by young people with a fixation or obsession with, and desire to commit, acts of extreme violence.

> *“… the issues and evidence are nevertheless broad in compass”*

Whilst the scope of the Southport Inquiry is considerably more focused than many other inquiries (most obviously the UK Covid-19 Inquiry which arguably has a scope unequalled to any other public inquiry), the issues and evidence are nevertheless broad in compass. The Inquiry has heard detailed evidence about the mental health and local authority assessments conducted with the perpetrator. At the other extreme, the Inquiry heard from a spokesperson of the social media company, X, and her invocation of Benjamin Franklin in support of freedom of speech. Despite its breadth, the Inquiry has ‘moved at pace’: over nine weeks of hearings, 25 impact statements and commemorative portraits have been presented and over 60 witnesses have given live evidence, with many more statements having been provided. The Chair, Sir Adrian Fulford, is expected to publish his Phase 1 report in early 2026. If this is achieved, it will have been delivered within a year of the Inquiry being formally established. By comparison with many other public inquiries, this will be an impressive achievement.

The profoundly troubling issues raised by the attack on 29 July 2024 necessitate an urgent consideration of what went wrong. The Southport Inquiry has worked with alacrity to ensure this can happen. It shows what can be done.

Inquiry-land 4: The Undercover Policing Inquiry – 10 years on

Claire Palmer reminds us that some public inquiries achieve faster results than others

Ten years on from its official set up date in July 2015, the Undercover Policing Inquiry is only part way through its hearing of the evidence. As of December 2025, the Inquiry is still in Phase 1 (Tranche 3), hearing evidence in respect of the period up to 2006. It will not be lost on readers that that is some 20 years ago.

It was announced this year that the Chair, Sir John Mitting, will stand down at the end of completing the SDS evidence and having produced his reports on those elements of the Inquiry.

So far, the Inquiry has only published one report: an Interim Tranche 1 report in respect of the period 1968 to 1982. A new Chair is expected to be appointed in due course, although no

Inquiry-land 4: The Undercover Policing Inquiry – 10 years on

Claire Palmer

announcement has yet been made, and will take the Inquiry through to its conclusion. This looks unlikely to be before 2027, and it could well stretch further. The Inquiry's website simply states that further details on the remainder of Tranche 3 hearing dates will follow, with hearings into 2026. Dates have not yet been set for Tranche 4 (Senior Officer and HMG Knowledge) and Tranche 5 will then follow.

Even by 2015, the approach to undercover policing had changed considerably from the relevant period with many lessons already arguably learned. Any Inquiry that seeks to investigate events over a period of 50 years was always going to be a challenge and perhaps one which is impossible to achieve. Seeking to run a public Inquiry into such a sensitive topic has added significantly to the work required and time taken. However, with the pace of progress to date, it may be thought that any value the Inquiry can add to this area of policing reduces ever further and there is a risk of decreasing relevance. Reports of the hearings in the mainstream media are now extremely limited. The speed of progress has led to already fading memories being further impacted, with many officers no longer well enough to give evidence, and a number who have sadly died. On reflection, a more targeted and proportionate approach may have yielded a swifter conclusion for all those affected by the issues.

Inquiry-land 5: A Brook too far?

Jennifer Wright reflects on the challenges faced in implementing the recommendations of the Brook House Inquiry

The Brook House Inquiry ("BHI") examined the decisions, actions, and circumstances surrounding the mistreatment of individuals detained at Brook House Immigration Removal Centre as shown in the BBC Panorama programme 'Under-Cover: Britain's Immigration Secrets,' which aired in September 2017.

> *"The Claimants submitted that the failure to fully implement the recommendations amounted to a failure to learn lessons and rectify dangerous practices and placed the Home Secretary in breach of the Article 3 investigative and systems duties"*

In her report of 19 September 2023, Chair Kate Eves identified 19 incidents where there was credible evidence of mistreatment capable of amounting to inhuman and degrading treatment pursuant to Article 3 of the European Convention on Human Rights ("ECHR"). The report noted that the failure to learn lessons from past incidents "runs as a dark thread through this report." In making her 33 recommendations, Ms Eves commented:

> "My Report comes as the latest in a long line of reports and investigations into immigration detention – many, with depressing regularity, making broadly similar findings and recommendations. It has long since been time to act on recommendations, rather than simply keep repeating them."

In June 2025, the implementation of the BHI recommendations was challenged in two linked claims for judicial review by formerly detained persons: *R (on the application of (1) D1914 and (2) AAA) v Secretary of State for the Home Department*; *R (on the application of AVY) v Secretary of State for the Home Department* [2025] EWHC 1853 (Admin). The Claimants submitted that the failure to fully implement the recommendations amounted to a failure to learn lessons and rectify dangerous practices and placed the Home Secretary in breach of the Article 3 investigative and systems duties. D1914 and AAA further argued that the response to the recommendations contravened the statutory objects and purposes of the Inquiries Act 2005.

Inquiry-land 5: A Brook too far?

Jennifer Wright

> *"millions of pounds are spent on public inquiries, yet too little is done to ensure that the desired outcomes of inquiries are achieved. Implementation monitoring is an essential – but currently neglected – part of the inquiry process"*

Lang J rejected these arguments, finding that there was no basis for extending the State's Article 3 investigative duty beyond the investigation to the actions taken in response. The report made "recommendations, not directions" [265] and BHI had no power to compel implementation. Given this, there was also no breach of the Inquiries Act 2005. On the substance of the response, the Judge found that all the accepted recommendations had either been substantially met or were in the process of being substantially met, and the decision not to accept certain recommendations was a reasonable exercise of executive discretion.

This judgment illustrates some key themes which continue to be the subject of discussion in the world of public inquiries more generally: firstly, that inquiries have no power to compel compliance with their recommendations and the government retains a discretion in respect of acceptance and implementation (which naturally have implications for policy, legislation, and resourcing). Secondly, that when it comes to the subject matter of many inquiry recommendations, it is not always straightforward to evaluate implementation, particularly given there is no express legal obligation on the government to respond to recommendations, explain decisions about acceptance or rejection, or publish updates on the progress of implementation. Concerns about the implementation of past recommendations has continued to be a central concern in subsequent inquiries, most notably the Thirlwall Inquiry, which examined the events at the Countess of Chester Hospital following the convictions of Lucy Letby.

On 16 September 2024, the House of Lords Statutory Inquiries Committee (to which Ms Eves gave evidence) published its report 'Public inquiries: Enhancing public trust.' The report identified implementation monitoring as a core issue, noting that "millions of pounds are spent on public inquiries, yet too little is done to ensure that the desired outcomes of inquiries are achieved. Implementation monitoring is an essential – but currently neglected – part of the inquiry process."

The Committee recommended the formation of a new, joint, parliamentary select committee to undertake formal implementation monitoring. In its response of 10 February 2025, the government accepted the need for reform, stating "[t]oo often, there has been insufficient transparency and accountability for implementation of inquiry recommendations that have been accepted by previous governments." Such concerns are not new, although they have come to the fore in recent years as high-profile public inquiries have continued to capture the interest and attention of the wider public. It remains to be seen whether this will prove a catalyst for change in an area where reform has been debated for so long.

Is an Inquiry a "Court or Tribunal"?

(and why does it matter?)

John Goss and Paige Jones

On 3 November 2025, Steyn J handed down her judgment following a case management conference in a judicial review of a decision by the Chair of the Independent Inquiry Relating to Afghanistan (IIA), the Rt Hon Sir Charles Haddon-Cave: *R (on the application of Witness IIA126) v Chair of the Independent Inquiry Relating to Afghanistan* [2025] EWHC 2842 (Admin).

Is an Inquiry a "Court or Tribunal"? (and why does it matter?)

John Goss and Paige Jones

In the usual way with public inquiries under the Inquiries Act 2005 ("the 2005 Act"), the IIA involves a number of Core Participants ("CPs"). This judicial review was brought by Witness IIA126, an anonymised Special Forces witness, in response to two linked decisions made by the IIA Chair relating to the holding of CLOSED hearings that exclude virtually all CPs.

> *"Ultimately, Steyn J determined that an inquiry was not a "court or tribunal"*

The substantive issue for Steyn J's determination, which is beyond the scope of this article, was to determine the jurisdictional basis for any closed material procedure ("CMP") in the JR proceedings, given the novel issue of the interplay between the statutory power to order a CMP pursuant to the Justice and Security Act 2013 on national security grounds, and the separate jurisdiction to do so under the common law identified by the Supreme Court in *R (Haralambous) v Crown Court at St Albans* [2018] UKSC 1; [2018] AC 236. But as part of the issues in the CMC, she also had to consider whether a public inquiry under the Inquiries Act 2005 is a "court or tribunal" within the meaning of paragraph 4.6(2) of Practice Direction 54A of the Civil Procedure Rules ("PD 54A"), which says:

> **4.6** (1) Any person who is an interested party (see rule 54.1(2)(f)) must be named in the Claim Form as such (see rule 54.6(1)(a))and served with the Claim Form (see rule 54.7(b)).
>
> (2) Where the claim for judicial review relates to proceedings in a court or tribunal, any other party to those proceedings will be an interested party in the judicial review proceedings. For example, if the defendant in a criminal case in the Magistrates' or Crown Court applies for judicial review of a decision in that case, the prosecution must always be named as an interested party in the judicial review claim.

> *"Ordinarily, a tribunal would be understood to be a judicial body which determines certain types of dispute. The Inquiry has not been set up to determine a dispute"*

One of the arguments advanced at the hearing was that the Inquiry was a tribunal, and that PD54A para 4.6 operates as a deeming provision which means that any participant in legal proceedings which are challenged by way of judicial review is to be treated as directly affected by that judicial review claim, and therefore falling within the definition of "interested party" in CPR 54.1(2)(f).

> *"To put it simply, since there is no dispute and no disagreement between parties in an inquiry but rather it is a fact-finding forum made up of Core Participants, it therefore is not a tribunal for the purposes of section 31 SCA. Consequently, it is also not a tribunal for the purposes of PD54A. Instead, an Inquiry is a public authority"*

Ultimately, Steyn J determined that an inquiry was not a "court or tribunal", setting out (at §40):

> I note that there is no definition of the term "court or tribunal" for the purposes of s.31(5A). In my judgment on the Royal Military Police's ('RMP') application to be joined as an interested party, addressing the RMP's reliance on para 4.6(2) of Practice Direction 54A, I ruled that the term "court or tribunal" in the Practice Direction should be interpreted consistently with that same term where it appears in s.31 of the SCA 1981. I held that the Inquiry does not fall within that term. It is obviously not a "court". Ordinarily, a tribunal would be understood to be a judicial body which determines certain types of dispute. The Inquiry has not been set up to determine a dispute. There is no *lis* between the Core Participants before the inquiry. There are no parties as such before the Inquiry. It follows that s.31(5)(b) and (5A) are inapplicable. Nevertheless, the point remains that s.31(2A), (3C) and s.31(5)(a) "postulate that the High Court will be considering the outcome on the same basis" (*Haralambous*, [58]) as the public body whose decision is subject to challenge.

To put it simply, since there is no *dispute* and no disagreement between *parties* in an inquiry but rather it is a fact-finding forum made up of Core Participants, it therefore is not a tribunal for the purposes of section 31 SCA. Consequently, it is also not a tribunal for the purposes of PD54A. Instead, an Inquiry is a public authority.

It is notable that this would almost certainly not have been the case prior to the 2005 Act: public inquiries were then unquestionably tribunals under the Tribunals of Inquiry (Evidence) Act 1921. As a result, many of the pre-2005 (and some post-2005) cases refer to public inquiries as 'tribunals'.

Is an Inquiry a "Court or Tribunal"? (and why does it matter?)

John Goss and Paige Jones

> *"The consequence of this decision is therefore that Core Participants to an inquiry do not have the automatic right to become Interested Parties in any related judicial review proceedings"*

But the language of 'tribunal' was not repeated in the 2005 Act, which seems to indicate a deliberate turn away from that approach.

The consequence of this decision is therefore that Core Participants to an inquiry do not have the automatic right to become Interested Parties in any related judicial review proceedings. Instead, any Core Participant seeking Interested Party status will have to satisfy the court on the facts that they are directly affected by the claim. That is in stark distinction to the position when an inquest is judicially reviewed – there can be no doubt that a coroner presides over an inferior court of record (*R v HM Coroner for West Yorkshire ex parte Smith (No 2)* [1985] QB 1096), and so all Interested Persons to an inquest must be named as Interested Parties to a judicial review claim.

As Steyn J identified, it also has an impact on the relief that can be granted in judicial review claims: by s.31(5)-(5B) of the Senior Courts Act 1981, it is only where the decision challenged was made by a court or tribunal that the High Court can, subject to other conditions being met, substitute its own decision. That may not make much practical difference: it can always remit the matter with a direction to take a decision in a particular way, but the technical distinction is important when considering the form of relief sought in any judicial review proceedings relating to inquiries.

There are other implications as well. First, this decision seems to close the door on any possibility that 2005 Act inquiries have any powers related to contempt of court that do not appear on the face of the Act itself. Those powers are primarily in s.36 relating to enforcement by the High Court or Court of Session. Since the power to refer a matter under s.36 depends on a failure to comply with a notice under s.21 of the 2005 Act, that is likely to give inquiry chairs narrower powers for dealing, for example, with contempt in the face of the court, such as a refusal to answer questions once sworn (though no doubt a brief s.21 notice could be produced in short order if it became clear one was required – albeit that that may in turn raise issues over the right of a recipient to apply to have it set aside).

Second, s.37(1) of the 2005 Act confers immunity from suit on the members of the inquiry panel (including assessors), and on counsel or solicitor to an inquiry as well as on a person engaged to provide assistance to an inquiry. But the immunity that s.37(3) applies to witnesses and to lawyers not acting for the inquiry is expressly stated to be 'for the purposes of the law of defamation' (s.37(3)), which is narrower than would be the case for proceedings in a court or tribunal: see *Chief Constable of Sussex Police v XGY* [2025] EWCA Civ 1230.

> *"… statutory inquiries therefore do not have the same trappings, and in some cases leeway, that courts or tribunals do …"*

Third, though inquiries are already treated separately from proceedings in court under s.32(2) of the Freedom of Information Act 2000, this ruling may cause some difficulties in data protection terms. One of the conditions permitting the processing of special category and criminal offence data under the UK GDPR, for example, is that it is done 'when a court or tribunal is acting in its judicial capacity' (para 34 of Schedule 1 of the DPA for criminal offence data; Art 9(2)(f) UK GDPR for special category data), which would not seem to apply to a 2005 Act inquiry. It might still fall within 'legal proceedings' (para 33 of Sch 1 for criminal offence data), but does not obviously fall within 'the establishment, exercise or defence of legal claims' under the other limb of Art 9(2)(f). That does not mean that there is no solution: those processing personal data in a 2005 Act inquiry are still carrying out 'the exercise of a function conferred on a person by an enactment' (para 6 of Sch 1 DPA) and by definition a statutory inquiry is into matters of substantial public interest (Art 9(2)(g)).

Though these points might seem merely technical, they in fact stem from the fundamental question of what the nature of a public inquiry actually is. Because Steyn J's ruling is clear that they are not courts or tribunals, statutory inquiries therefore do not have the same trappings, and in some cases leeway, that courts or tribunals do, and which the legal professionals involved will typically be familiar with. As a result, it may sometimes be helpful when working on an inquiry to pause and reflect on whether a particular power or procedural step is in fact available or appropriate – or whether the apparent similarity to proceedings in court has caused everyone to overlook that these are not court or tribunal proceedings. As we have suggested above in respect of data protection and contempt of court, it will almost always be possible to find an inquiry-specific route to the same outcome. The judgment in this case helps us to start from the right point on the map.

Time to refurbish the Victorian power to quash an inquest conclusion?

Alex Ustych considers whether an imminent appeal before the Supreme Court will be a catalyst for change

Practitioners have mixed feelings about the High Court's power to quash the outcome of a coronial investigation and order a new inquest pursuant to section 13 of the Coroners Act 1988.

> *"… the section 13 process is laborious, slow and expensive"*

On the one hand, it is essential to have a way to quash wrong conclusions after the Coroner becomes *functus officio* following the inquest's closure. The need for a new inquest most often arises where an error (factual, procedural or legal) is identified in the original inquest or pivotal new evidence (factual or expert) comes to light. Having a fresh inquest in these circumstances can be hugely meaningful to some bereaved families including by providing closure, for example in one case where development of DNA technology allowed the identification of a loved one's body decades after his death. The 2014-2016 Hillsborough Disaster inquests required the quashing of the original 1989-1991 inquests, otherwise they could not have taken place.

> *"… the legislation governing this procedure has not been fundamentally updated since Queen Victoria celebrated her Golden Jubilee"*

On the other hand, the section 13 process is laborious, slow and expensive. It involves making a formal application to the Attorney General for an 'authority' ('fiat') to apply to the High Court for a section 13 order. The process understandably requires liaison with the bereaved families at key stages. In the author's experience of representing Senior Coroners taking the initiative in pursuing this process, it is not an easy one for the families, and that liaison is often tricky. The proceedings in the High Court can then involve multiple procedural hoops to jump through, such as obtaining permission to issue a claim without naming a defendant, where the Senior Coroner is the applicant. The case must then be prepared for a hearing before the Divisional Court, with all the time, expense and delay that entails. It is frustrating for all concerned that this rather convoluted multi-stage process must be followed even where the deficiencies in the original proceedings/outcome, or the impact of the new evidence, are clear and it is blindingly obvious that a new inquest is "necessary or desirable in the interests of justice" (the key test in s. 13 (1)).

> *"The Supreme Court's consideration of section 13 may give impetus to a push for complete reform of how an order for a fresh inquest is sought"*

The lack of 'user friendliness' in this process is perhaps explained by the fact that section 13 is largely similar to s. 6 of the Coroners Act 1887; the legislation governing this procedure has not been fundamentally updated since Queen Victoria celebrated her Golden Jubilee.

This critique of the *status quo* is prompted by the Administrative Court's (Stuart-Smith LJ and Chamberlain J) important consideration of the status of the Attorney General's section 13 (1) function in the case of *R (on the application of Campbell) v Attorney General* [2025] EWHC 1653 (Admin). The Court determined that the Attorney General's refusal to provide authority (in the exercise of a public 'gate keeping' function) to initiate proceedings to quash an inquest conclusion was not justiciable. Permission was given in November last year for a leapfrog appeal to the Supreme Court. The Supreme Court's consideration of section 13 may give impetus to a push for complete reform of how an order for a fresh inquest is sought.

Campbell arises from the attack on the World Trade Centre. Geoffrey Campbell was unlawfully killed in the North Tower on 11 September 2001. On 29 January 2013, HM Senior Coroner for West London held an inquest, recording that the death was due to Al-Qaeda flying an aircraft into the building, causing its collapse. Mr. Campbell's brother, the claimant in the judicial review, does not accept that the building collapsed because of the impact of the aircraft. His alternative hypothesis is that the collapse was caused by the detonation of pre-planted explosives. He relied on fresh evidence not available to the

Time to refurbish the Victorian power to quash an inquest conclusion?

Alex Ustych

> *"… even if the section 13 case progresses to a hearing before the Divisional Court, its powers to rectify the issue/error directly are very limited"*

Senior Coroner in 2011-2013. The Solicitor General (acting on behalf of the Attorney General) refused, in 2023 and again in 2024, an authority under section 13 (1) (b) for Mr. Campbell's family members to apply to the High Court. The decision noted that the claimant's hypothesis was "fanciful" and "simply not credible". Reference was also made to the "long-standing principle outlined in *Gouriet v Union of Post Office Workers* [1978] AC 435 that the exercise of the Law Officers' discretion in public interest functions is absolute, and non-reviewable".

> *"The Court confirmed that, on a plain reading of the legislation, it does not have the power to amend a Record of Inquest by quashing specific wording and substituting its own. But it does have the power under section 13(2)(c) to amend part of a record by quashing, removing, or "red-lining" offending words, without necessarily ordering a fresh coronial investigation and inquest"*

The Administrative Court dealt with the justiciability point as a preliminary issue, finding against the claimant. The Court relied on *Gouriet* and *R. v Solicitor General Ex p. Taylor* (1996) 8 Admin. L.R. 206, the latter case being a failed challenge to the Attorney General's function of consenting to proceedings for contempt of court under the Contempt of Court Act 1981. The Court in *Campbell* found that an immunity arose because of the unique constitutional position of the Attorney General, applying both to prerogative and statutory functions, and depended on the nature/subject matter of the function to be reviewed. The category of functions whose exercise was non-justiciable included powers to enforce the law by bringing criminal or civil proceedings in the public interest and powers to authorise or terminate such proceedings by others (section 13 (1) (b) included). This 'gate keeping' function entrusted to the Attorney General by Parliament was determined necessary because the public interest might be damaged if the proceedings in question could be brought by private individuals without any filter. In the coronial context, the filter promoted the public interest in legal certainty.

Another argument for reform of this process is that, even if the section 13 case progresses to a hearing before the Divisional Court, its powers to rectify the issue/error directly are very limited. In most cases where the application succeeds, a fresh inquest will be necessary (with the delay and anguish for the family that this often entails). This is the case even where the correct conclusion to be substituted is uncontroversial. In *R (Shipsey) v Senior Coroner for Worcestershire* [2025] EWHC 605, the Divisional Court considered the extent of its powers under section 13(2)(c) when reviewing a Record of Inquest. The Court confirmed that, on a plain reading of the legislation, it does not have the power to amend a Record of Inquest by quashing specific wording and substituting its own. But it does have the power under section 13(2)(c) to amend part of a record by quashing, removing, or "red-lining" offending words, without necessarily ordering a fresh coronial investigation and inquest. It follows that it may be an appropriate exercise of the section 13 (2) (c) discretion to quash part of a determination or finding, but not the entire Record of Inquest. A further recent case about the application of the 'interests of justice' is *Senior Coroner for Northamptonshire v Lovell and Teague* [2024] EWHC 2331 (Admin), in which the High Court considered that the public airing of the underlying concern in the course of the section 13 application itself was sufficient to remedy the concern and avoid a further inquest.

> *"It will be interesting to see whether the high-profile examination of the section 13 process in the Supreme Court will trigger an overhaul, or at least a substantial streamlining, of this important process"*

While *Shipsey* gives the Court greater latitude than was previously understood, the limitation of the section 13 power as currently drafted is also clear. The Court can tweak the Record of Inquest through targeted deletion, but not substitute one conclusion for another, even if it is the only one lawfully available on the evidence as it stands. This position stands in contrast with the Administrative Court's power in s. 31 of the Senior Courts Act 1981 by which it can substitute its own decision for the decision in question in a judicial review. There will be cases where the Record of Inquest is quashed and it would be inappropriate to substitute the High Court's own conclusion, for example where the inquest was an Article 2 inquest with a jury. However, in the author's experience, there are many more section 13 cases where it would be appropriate for the High Court to simply substitute the only conclusion properly available on the evidence/law, thereby sparing everyone the further expense, cost and anguish of a fresh inquest. There are many such cases where all concerned would be content with this expedited process. It is difficult to see why section 13 should not be amended to give the Court the option to adopt this course in appropriate cases.

It will be interesting to see whether the high-profile examination of the section 13 process in the Supreme Court will trigger an overhaul, or at least a substantial streamlining, of this important process.

I'm just plain Soldier D – Anonymity, functus officio, and the role of the coroner

Bobby Talalay

A recent decision of the Court of Appeal in Northern Ireland emphasises the importance of raising all matters for determination with the Court before the Coroner concludes the inquest and becomes functus. After the inquest is closed, it is too late to do anything about it, short of seeking an order from the High Court that the inquest is reopened (or if it falls under the slip rule).

> *"For the avoidance of any doubt a coroner should state clearly when the inquest is being opened, adjourned and closed. This should ideally be in open court but may be done in writing where appropriate"*

In *Re Thompson's Application for Judicial Review* [2025] NICA 25, the Court was considering the inquest into the death of Kathleen Thompson in 1971. The initial inquest returned an open verdict, but a fresh inquest was opened in 2013, resumed in 2021, and closed in 2022. A number of witnesses gave evidence on the basis that they could assist the inquest; one of whom was Soldier D, who was granted anonymity by the Coroner during the proceedings. At the end of the fresh inquest, the Coroner ruled that, on the balance of probabilities, Soldier D had shot the deceased in circumstances that were not justified. The Coroner stated her findings in open court and then later in written reasons. After the written reasons were promulgated, the deceased's daughter (the Claimant in the judicial review proceedings), requested that the Coroner reconsider the issue of Soldier D's anonymity. The Coroner refused to do so as (a) she considered she was functus officio and (b) although she had referred Soldier D to the Director of Public Prosecutions (DPP), she would not have altered her anonymity order. The Claimant sought to review that decision, first in the High Court and then on appeal to the Court of Appeal.

The Court of Appeal first had to determine when the Inquest was concluded and held (in the Northern Irish context) it was when the Coroner delivered her written rulings. In England and Wales, the position is perhaps simpler and can be found in Chapter §13 of the Chief Coroner's Guidance for Coroners on the Bench, which provides that the inquest is concluded when the record of inquest is signed (except for the purpose of considering Prevention of Future Deaths reports).

Second, the Court looked at the implications of being *functus* and held that it related to the Coroner's investigative function. Applications concerning anonymity fall within that function and so the power to make or change anonymity rulings ends with the conclusion of the inquest. However, there exist other separate functions, apart from the investigative role, which continue after the conclusion of the inquest; in this case, referral of an individual to the DPP, but one can also conceive of other powers, not least PFD obligations as set out in the statute, but also obligations such as those under the Data Protection Act 2018.

> *"Interested Persons should seek to identify any ancillary issues as soon as possible after findings are promulgated"*

Third, the Court of Appeal gave useful guidance on how to avoid issues such as this in the future:

- For the avoidance of any doubt a coroner should state clearly when the inquest is being opened, adjourned and closed. This should ideally be in open court but may be done in writing where appropriate.
- It is best practice to give advance warning of the coroner's intention to close the inquest to Interested Persons.
- Interested Persons should seek to identify any ancillary issues as soon as possible after findings are promulgated.
- A coroner, after making a finding which is critical of the behaviour of an individual with anonymity, should consider whether the situation necessitates reconsideration of the issue of anonymity and should seek submissions from the Interested Persons in this regard.

I'm just plain Soldier D – Anonymity, functus officio, and the role of the coroner

Bobby Talalay

So, it might be useful to restate the principles applicable in anonymity applications, summarised by the Court of Appeal in *R (T) v West Yorkshire (Western Area) Senior Coroner* [2021] Q.B. 205 at [55-64]. The starting position is one of open justice, an important part of which is the naming of individuals, and any restriction on open justice requires cogent justification. Coroners have power, however, to grant anonymity as part of their case management powers where to do so would be justified. There are different potential justifications for doing so, including whether there was a real and immediate risk to the witness' life or of inhuman or degrading treatment, or whether the balance (taking into account an individual's right to privacy or of common law fairness) fell in favour of anonymity. What then must be considered is the fact-sensitive application of those principles in each case.

But the take-home point from *Thompson* is that all these arguments must be made before the Coroner closes the inquest, or they cannot be made at all.

Resuming inquests: A Coroner's dilemma

Mark Thomas

Picture a tragedy: a criminal trial, a conviction for murder, grieving and traumatised families. Should the legal proceedings end there, or should a Coroner resume their investigation and move the army of lawyers from the criminal courts to their own? And for what purpose?

The decision to resume an inquest following a homicide trial turns on a deceptively simple-looking provision at paragraph 8 of Schedule 1 to the Coroners and Justice Act 2009: where an investigation has been suspended pending criminal proceedings, it "may not be resumed unless – but must be resumed if – the senior coroner thinks there is sufficient reason for resuming it".

The wording of the statute suggests that the Senior Coroner has a wide discretion to make that decision. But what counts as a "sufficient reason"?

In judging whether there is sufficient reason for resumption, the Coroner must consider three key issues:

a. Is Article 2 ECHR is engaged?

b. If Article 2 is engaged, is the totality of the previous investigations sufficient to discharge the Article 2 investigative obligation?

c. If Article 2 is not engaged, is there sufficient reason to resume the inquest in any event?

Once criminal proceedings have concluded, it is usually the case that the state will have conducted a multitude of investigations or reviews – each with a slightly different purpose and process. Article 2 does not prescribe the form of the investigation(s) that must take place to satisfy the procedural duty, but the minimum requirements collectively are set out in *Jordan v United Kingdom* (2001) E.H.R.R. 52, *Edwards v United Kingdom* (2002) 35 E.H.R.R. 487 and *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51. They are often (imaginatively) referred to as the Jordan requirements:

a. The authorities must act of their own motion;

b. The investigation must be independent;

c. The investigation must be effective in the sense that it must be conducted in a manner that does not undermine its ability to establish the relevant facts – "an obligation of means rather than results";

d. The investigation must be reasonably prompt;

e. There must be sufficient elements of public scrutiny of the investigation or its results to secure accountability;

f. There must be involvement of the next of kin "to the extent necessary to safeguard his or her legitimate interests".

Resuming inquests: A Coroner's dilemma

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This tempts us to embark on a 'top trumps' style comparison of the investigations that have already occurred with those in other cases to establish whether those investigations are sufficient to avoid an inquest, or 'not enough' leading to a requirement that one be held (depending on the position of a particular IP). However, such comparisons are fraught.

In *R (AP) v HM Coroner for the County of Worcestershire* [2011] EWHC 1453 (Admin), it was held that the combination of a police investigation, an IPCC report, and a local authority social services complaint investigation was sufficient to satisfy the Article 2 investigatory duty. The relevant facts surrounding the death had been fully ascertained, the IPCC report was independent, and the next-of-kin was able to play a part in both the IPCC and the local authority investigations. The results of the two investigations were published. Systems were reviewed and improved, and individuals were given management advice.

In contrast, in *R (Silvera) v HM Senior Coroner for Oxfordshire* [2017] EWHC 2499 (Admin), it was found that the investigations that had taken place to the date of judgment had not been sufficient, even taken together, to discharge the Article 2 investigative obligation. There had been no Crown Court trial, there had only been an internal NHS trust investigation "that was carried out in private", and a domestic homicide review, which "was expressed to be private and confidential".

In *R (on the application of Grice) v HM Senior Coroner of Brighton and Hove* [2020] EWHC 3581 (Admin), it was held that the Coroner was entitled not to resume an inquest where there had been a conviction for murder in the Crown Court, a statutory Domestic Homicide Review, an IOPC investigation, an investigation by HM Inspectorate of Constabulary and Fire & Rescue Services, and proceedings under the Police (Conduct) Regulations where findings of misconduct and gross misconduct were made against three officers.

And so, since 2017, we've had two apparently contrasting authorities with the common thread that the exercise of the Coroner's discretion depends heavily on the facts, including weighing the apparent quality, independence, transparency, and family participation of prior investigations.

The recent case of *R (Bailey) v HM Senior Coroner for East London* [2025] EWHC 1637 (Admin) concerned the tragic death of a 14 year old boy after being stabbed. The criminal trial resulted in a murder conviction. Following that, there was a Serious Case Review and a police re-investigation. The Deceased's mother asked the Coroner to resume the inquest and the Coroner declined.

When considering the mother's claim for judicial review, Swift J. re-affirmed that Coroners retain a broad discretion as to resumption, but the Judge acknowledged that a decision not to resume carries risk. The mother argued that (i) the Serious Case Review and other investigations lacked adequate independence, public scrutiny, and meaningful family involvement, (ii) the possibility of a narrative conclusion or a PFD report under Regulation 28 might bring to light system lessons, and (iii) there was a powerful public interest in a resumed inquest.

> *"whenever considering a document such as this SCR report it will always be possible to point to further questions that could have been considered or further details that could have been looked for. But that is not the test of whether the investigation that has been undertaken meets the requirements arising under article 2"*

Ultimately, however, the Court accepted that the trial, serious case review, and police re-investigation, already covered the core factual ground and that a resumed inquest would add little to that which was already known. Swift J. commended the Serious Case Review in particular, stating that it was "a highly impressive piece of work". He noted that "whenever considering a document such as this SCR report it will always be possible to point to further questions that could have been considered or further details that could have been looked for. But that is not the test of whether the investigation that has been undertaken meets the requirements arising under article 2". The investigation discharged the Article 2 investigative duty and there was, in short, insufficient reason to resume the inquest.

So, where does this leave us? The interplay of *AP*, *Silvera*, *Grice* and *Bailey* show that the Coroner's decision on resuming an inquest following a homicide conviction is finely balanced. The Coroner must weigh:

- The public inquest in transparency, accountability and learning lessons;
- The independence and effectiveness of other investigations;
- The participation of the family in prior reviews and investigations; and
- Whether a resumed inquest would add factually to the narrative.

It seems that we'll be playing investigation 'top trumps' for a while yet.

Article 2: Through the Prism of Three Police Related Deaths

Alison Hewitt

You would be forgiven for thinking that further input from the High Court as to the engagement of Article 2 ECHR in inquests can add little to the recent extensive reviews of the underlying principles by the appeal courts.

But three decisions from 2025 (**Ferguson, Rizvi** and **Robinson**), all arising from deaths concerning the police, are of interest as they grapple with fact-specific scenarios at different stages of the inquest process.

The judgment of Hill J. in *R (Ferguson) v HM Assistant Coroner for Sefton, Knowsley and St. Helens and the Chief Constable of Merseyside* [2025] EWHC 1901 (Admin) provides an extremely useful summary of the legal principles underlying Article 2 engagement, as well as helpful guidance on when a jury must be summoned because of police involvement.

The Facts and Evidence

The inquest concerned the death of James Farley who suffered psychosis and who jumped to his death from the fourteenth floor of a car park in Bootle, Merseyside. Arguments as to Article 2 arose because, about 20 minutes earlier, he had been seen on the roof of a different car park by police officers. He had been reported to be crying and "*having a bit of a meltdown*". Mr Farley told the officers that he was drunk and had voices in his head, but that he was "fine" and that he did not intend to harm himself. The officers accompanied him out to the street and made a "vulnerable persons' referral". The Deceased then told them that he was planning to go home. Merseyside Police's Professional Standards Department subsequently investigated and concluded that the officers had not breached the force's "Responding to People with Mental Ill-health or Learning Disability" policy, and their decision not to detain under s.136 of the Mental Health Act had been acceptable, but that more could have been done to support the Deceased. The officers had been "too easily swayed" by Mr Farley's assurances; they had not questioned what the voices in his head were telling him and, if they had, this may have triggered different considerations and options; they had not sought the support of a mental health professional, which was available through the "mental health triage car" or urgent Careline, a failure which was described as "pivotal"; this would have enabled investigation of the Deceased's history which would have informed their risk assessment, and could have resulted in more positive action for safeguarding (such as persuading him to go to hospital or taking him to a family member whilst he was drunk and in crisis).

The Assistant Coroner's Decisions

In written submissions to the Assistant Coroner, the Deceased's brother argued that (i) the investigatory duty under Article 2 was engaged because the conduct of the officers arguably constituted a breach of the Article 2 operational duty and because inadequate police procedures arguably constituted a breach of the Article 2 systems duty, and (ii) a jury was required for the inquest as there was at least "reason to suspect" that the death resulted from an act or omission of a police officer. The coroner rejected both submissions.

Ruling on Article 2

Hill J. set out her succinct but comprehensive review of the relevant legal principles relating to the engagement of Article 2 at paragraphs 14 to 37 of her judgment (which, as stated above, is a very useful summary). Her Ladyship noted that, when considering matters at the pre-inquest stage, the threshold for finding both an *arguable duty* and an *arguably breach* of that duty is low; this had been emphasised by Popplewell LJ in *R (Morahan) v West London Assistant Coroner* [2021] EWHC 1603 (Admin); the threshold for investigating a potential breach is much lower than that for finding (on the basis of all the evidence) that there has actually been a breach.

> *"…the Judge considered that there were further enquiries which the officers could have made and that it was at least arguable that, had they been made, the police would have appreciated that the risk of suicide was not remote or fanciful but was objectively well-founded and "present and continuing""*

The Court upheld the coroner's view that there was no

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evidence of a breach of the systemic duty as it was clear that the police had established systems, policies and procedures to enable a proper response for the welfare of vulnerable people, but Hill J. found that the coroner's decision was flawed in relation to the operational duty. In applying the low threshold to the available evidence, including the PSD investigation outcome, the Judge considered that there were further enquiries which the officers could have made and that it was at least *arguable* that, had they been made, the police would have appreciated that the risk of suicide was not remote or fanciful but was objectively well-founded and "present and continuing". So far as the well-known indicia set out by Lord Dyson in *Rabone v Pennine Care NHS Trust* [2021] 2 AC 72 were concerned, Hill J. concluded that it was at least arguable that the officers had assumed responsibility for Mr Farley, given that they had attended in response to a 999 call for the specific purpose of protecting him from the risk of self-harm or suicide, had assured him that they were there because they were "*worried about*" him, and had told him they would take steps to protect him by completing a vulnerable person's referral; although he was not in fact detained under s.136 of the MHA and thereby in the control of the state, it was arguable that he could have been, and regard must be had to what the officers should have done as well as what they had done. Further, Mr Farley was especially vulnerable by reason of his psychosis (of which the officers were aware) and death by suicide in the course of a psychotic episode was an "exceptional" rather than an "ordinary" risk. In the circumstances, it was arguable that the officers owed the positive operational duty to the Deceased and arguable that it had been breached (there being no evidence that it would have placed a disproportionate burden on the officers to have conducted further enquiries).

The Judge found the coroner to be in error also in relation to causation. She explained that, in order to assess whether there was an arguable breach of the operational duty, the coroner was required to determine whether it was arguable that the officers had failed to take measures which "could reasonably be expected…to avoid the risk" (see *Morahan* at [38]). The test for causation is "whether the Deceased lost a substantial chance of surviving because of the breach": *R (Boyce) v Teesside and Hartlepool Senior Coroner* [2022] EWHC 107 (Admin) at [45] citing *Van Colle v Chief Constable of Hertfordshire Police* [2009] AC 225 at [138]. However,

> *"The coroner had directed himself that the phrase "act or omission" should be interpreted as importing a requirement for some form of inappropriate act by the officer but the Court said that there was no authority which supported placing such a gloss on the statutory wording"*

the Coroner had not applied this test, but instead that of "coronial causation", referencing both the "more than minimal, negligible or trivial contribution" and the "actual and material contribution" tests. On the basis of the correct legal test, Hill J. considered that the threshold for arguable causation was also met on the evidence.

Overall, therefore, the coroner had been wrong to find that the investigative duty under Article 2 was not engaged.

Ruling on the Need for a Jury

Section 7(2)(b) of the Coroners and Justice Act 2009 states that an inquest must be held with a jury if the senior coroner has reason to suspect that the death resulted from an act or omission of a police officer in the purported execution of the officer's duty as such. The coroner had directed himself that the phrase "act or omission" should be interpreted as importing a requirement for some form of inappropriate act by the officer but the Court said that there was no authority which supported placing such a gloss on the statutory wording. The "reason to suspect" test was described by the Divisional Court in *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin) as having a low threshold and being objective in its nature, and self-inflicted deaths can, and often do, "result from" both the actions of the Deceased and the acts or omissions of the state. Hill J. concluded that, as the only rational conclusion on the evidence was that there was reason to suspect that the police attending Mr Farley could or should have done more, this threshold was met and a jury was therefore required.

> *"At the end of the evidence, the arguability of an Article 2 breach was no longer the question; rather, the classic Galbraith approach of considering the sufficiency of the evidence was the test to be applied. If it was not safe to leave a finding to the jury, then it should not be left, whether or not the investigative duty under Article 2 had been engaged in the inquest."*

Whilst ***Ferguson*** reiterated that the threshold for arguability is low at a pre-inquest stage, ***R (Rizvi) v HM Assistant Coroner for South London*** [2025] EWHC 3014 (Admin) illustrates the different approach needed for a coroner's assessment at the end of the evidence. Sabina Rizvi died in 2003 after collecting her boyfriend from a police station. As they drove away, she was shot in a planned "gang shooting". Many years after the homicide trial of the organiser, the coroner was persuaded to resume

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the inquest on the basis that there was an *arguable* operational duty, and an *arguable* breach of that duty by the police. The coroner held an Article 2 compliant inquest in 2024 and investigated whether the police should have appreciated that there was a real and immediate risk to Ms Rizvi's life and should have taken steps to mitigate that risk. However, at the end of the evidence the coroner decided not to leave any findings of fact to the jury regarding acts or omissions by the police, on the basis that it would be unsafe to do so, and this was challenged by the family. Foxton J. had no hesitation in upholding the decision. At the end of the evidence, the *arguability* of an Article 2 breach was no longer the question; rather, the classic *Galbraith* approach of considering the *sufficiency* of the evidence was the test to be applied. If it was not safe to leave a finding to the jury, then it should not be left, whether or not the investigative duty under Article 2 had been engaged in the inquest.

Finally, ***R (Robinson) v HM Assistant Coroner for Blackpool and Fylde and the Chief Constable of Lancashire Police*** [2025] EWHC 781 (Admin) arose from the death in 2021 of a driver in Blackpool (Mr Robinson) who, after being stopped by two police officers, got out of his car and was seen to place an object in his mouth. The officers suspected it to be a package of drugs, and they handcuffed him on the ground and tried to remove it. When the Deceased stopped resisting, they removed the handcuffs and called an ambulance, suspecting that he had swallowed the drugs and was suffering from their effects. In fact, the package was blocking Mr Robinson's airway, but the officers did not realise this. He suffered a cardiac arrest, and the officers inserted a breathing airway and commenced cardiopulmonary resuscitation. When the ambulance arrived, the first paramedic thought the Deceased's airway was clear because there was a breathing device in place. It was only after he was moved to the ambulance that a second paramedic saw the blockage and it was removed. Mr Robinson died after arriving at the hospital and, at post-mortem, it was confirmed that the death had resulted from an obstructed airway which left the Deceased unable to breathe. The pathologist could not say whether removal of the package at the roadside, several minutes earlier, would have affected Mr Robinson's chance of survival, but did state that the restraint did not contribute to the death.

> *"On review, Kerr J. upheld the coroner's decision. He could see no good reason to extend the existing categories of case in which Article 2 automatically applies to include the circumstances preceding Mr Robinson's death; even though he was "in custody" (under restraint) when he suffered the obstruction, his death was from misadventure. The automatic Article 2 categories arise because the state will always need to explain how a death came about in the relevant circumstances, for example when a suicide occurs in custody. But cases of misadventure, even if occurring in police custody, may be unpredictable and the state agent may bear no blame for it"*

The evidence at the inquest recognised that the officers had faced a challenging situation but suggested that there had been delay in starting resuscitation and a missed opportunity to recognise the obstruction and "administer blows to the back" in an effort to dislodge it. At the close of the evidence, it was submitted by the family that Article 2 was engaged on the basis of the actions of the police and that, consequently, the jury could record judgmental findings and the coroner could, in his discretion, ask them to consider matters which possibly (as well as probably) contributed to the death. The coroner disagreed and the jury went on to record a short form conclusion of "misadventure". On review, Kerr J. upheld the coroner's decision. He could see no good reason to extend the existing categories of case in which Article 2 *automatically* applies to include the circumstances preceding Mr Robinson's death; even though he was "in custody" (under restraint) when he suffered the obstruction, his death was from misadventure. The automatic Article 2 categories arise because the state will *always* need to explain how a death came about in the relevant circumstances, for example when a suicide occurs in custody. But cases of misadventure, even if occurring in police custody, may be unpredictable and the state agent may bear no blame for it. Further, Kerr J. found that if the operational duty arose at all on the facts, it was not arguably breached because the officers did not fail to take reasonable steps within their powers to protect the Deceased's life. Although it was arguably that they should have commenced resuscitation a few minutes earlier, that would probably not have made any difference to the outcome, and the judge considered that other criticisms raised by the family were "far-fetched and informed by hindsight": these included failures by the officers to handcuff Mr Robinson sooner, to prevent him putting the package in his mouth, and to carry out a risk assessment before restraining him on the ground with the package in his mouth.

A Note from the Editors: the Police Accountabilty Rapid Review (*Maughan* revisited?)

Alison Hewitt and Mark Thomas

Are changes to the standard of proof for the "unlawful killing" conclusion in inquests now in the pipeline?

In October 2024, following the acquittal of Metropolitan Police firearms officer Martyn Blake of the murder of Chris Kaba, the Home Secretary and the Lord Chancellor appointed Sir Adrian Fulford and Timothy Godwin to undertake a rapid review looking at two issues arising from recent Supreme Court judgments:

i. In *R (Officer W80) v Director General of the Independent Office for Police Conduct* [2023] UKSC 24 (concerning the fatal shooting of Jermaine Baker by Officer W80), the Supreme Court decided that the test to be applied in disciplinary proceedings in relation to the use of force by a police officer in self-defence is the civil law test and the reviewers were asked to consider whether the criminal law test should be adopted, and

ii. In *R (Maughan) v HM Senior Coroner for Oxfordshire* [2020] UKSC 46, the Supreme Court ruled that the standard of proof for all conclusions at an inquest, including "unlawful killing", is the civil standard (the balance of probabilities) and the reviewers were asked to consider whether the criminal standard of proof should be adopted.

The review took place between November 2024 and May 2025 and resulted in recommendations for the adoption of the criminal test (for police disciplinary proceedings) and the criminal standard of proof (for the conclusion of "unlawful killing" in inquests). Extensive reasons were given but the Executive Summary stated as follows:

"It is frequently suggested that the result of the decisions in Maughan and W80 has been to assist in the important objective of reassuring the public that when police officers use unreasonable force in the discharge of their duties, a conclusion of unlawful killing at a Coroner's Inquest or a finding of misconduct or gross misconduct in disciplinary proceedings will lead to greater police accountability and improvements in training and learning. Although we readily understand this widely-held perception, we consider it is based on a fundamental misunderstanding of the processes and procedures relating to inquests and misconduct hearings. For the reasons set out below, it is our view that there are impressive mechanisms for achieving accountability, enabling lessons to be learnt and identifying relevant training irrespective of the changes or clarification brought about by the decisions in Maughan and W80. Instead, there are indications that the adverse impact on police morale, recruitment and retention following these two decisions has been significant, troubling and enduring. Perhaps most significantly, we have seen the figures for the required and actual number of Counter Terrorist Specialist Firearms Officers (CTSFOs) and Armed Response Vehicle (ARV) officers within the Metropolitan Police and there is a significant gap. There is, at the least, a potential problem with recruitment and retention in this critical area of policing within certain areas of England and Wales. We recognise this is the result of a complex picture of which the decisions in Maughan and W80 are only a part, albeit in all likelihood a significant part

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> - ***The Home Secretary has accepted the recommendation concerning police disciplinary proceedings and will lay changes to the Police (Conduct) Regulations 2020, following a consultation with the Police Advisory Board for England and Wales, and***
> - ***On the standard of proof for unlawful killing, the Lord Chancellor is minded to accept the recommendation to consult and will seek further agreement on the detail of a consultation paper in due course."***

A Note from the Editors: The Police Accountability Rapid Review (*Maughan* revisited?)

Alison Hewitt and Mark Thomas

> *"In any event, coroners and inquest practitioners must now await the outcome of further consultation so far as the unlawful killing conclusion is concerned. In the meantime, we will note that, in the special edition of this publication which was dedicated to assessing the impact of the Supreme Court's decision in Maughan (special edition of this publication), we raised concerns about the consequences of lowering the standard of proof for a finding of "unlawful killing" at an inquest; many of those concerns persist and, arguably, provide reasons to support a reversion to the criminal standard of proof."*

given the decisions have gained something of a totemic status as providing a disincentive for applying for, or remaining in, these particular roles."

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The Government's response stated that its "*accountability review set out bold plans to ensure that the police have the confidence of the communities they serve, and that officers also have the confidence that they need to do their vital and often extremely difficult job of keeping us all safe*".

Immediate responses to the proposed changes were mixed. The Metropolitan Police Commissioner, Sir Mark Rowley, was predictably pleased. He stated, "*This is not about avoiding accountability, nor is it about giving officers permission to use excessive force, or to use it recklessly. The force officers use will still need to be necessary, reasonable and proportionate in all the circumstances. But when the review's recommendations are implemented, officers will be able to have greater confidence that they will be held to a consistent standard, judged on what they honestly believed at the time and not what others say they should have believed many months and years after an incident. The need for this change is urgent and it is vital that implementation now follows without delay*."

But the reaction of Deborah Coles, Director at INQUEST, expressed dismay. She said, *"These new measures undermine the rule of law and the way it applies to police officers, increasing impunity and injustice. All the evidence is that what is needed is exactly the opposite. The Home Office has once again ignored the experience of bereaved families by parroting the concerns of the police lobby."* The charity was also critical of the fact that, in the Review's own words, the process had been "*an exercise in evaluating competing contentions on questions of policy"* rather than its conclusion being *"influenced to a large extent by statistics concerning trends prior to and post Maughan and W80"* as had originally been anticipated (see para 23 of the Rapid Review report).

In any event, coroners and inquest practitioners must now await the outcome of further consultation so far as the unlawful killing conclusion is concerned. In the meantime, we will note that, in the special edition of this publication which was dedicated to assessing the impact of the Supreme Court's decision in *Maughan* (special edition of this publication), we raised concerns about the consequences of lowering the standard of proof for a finding of "unlawful killing" at an inquest; many of those concerns persist and, arguably, provide reasons to support a reversion to the criminal standard of proof.

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